

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	<p>Initial Comments</p> <p>This findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the Focused State Relicensure survey conducted in your agency on 11/01/10 - 11/15/10. The Focused State Relicensure survey was conducted at your agency by authority of Chapter 449, Personal Care Agencies.</p> <p>The patient census was 240. Ten client records were reviewed. Two client home visits were conducted. Six client telephone interviews were conducted. Ten employee files were reviewed.</p> <p>The following regulatory deficiencies were identified:</p>	P 000		
P 060	<p>Section 14.1(2) Administrator Responsibilities</p> <p>2. The administrator of an agency shall represent the licensee in the daily operation of the agency and shall appoint a person to exercise his authority in his absence. The responsibilities of an administrator include, without limitation:</p> <p>(a) Employing qualified personnel and arranging for their training;</p> <p>(b) Ensuring that only trained attendants are providing services to a client of the agency and that such services are provided in accordance with the functional assessment of the client, the service plan established for the client and the</p>	P 060		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 060	<p>Continued From page 1</p> <p>policies and procedures of the agency; (c) Developing and implementing an accounting and reporting system that reflects the fiscal experience and current financial position of the agency; (d) Negotiating for services provided by contract in accordance with legal requirements and established policies of the agency; (e) Providing oversight and direction for attendants and other members of the staff of the agency as necessary to ensure that the clients of the agency receive needed services; (f) Developing and implementing policies and procedures for the agency, including, without limitation, policies and procedures concerning terminating the personal care services provided to a client; (g) Designating one or more employees of the agency to be in charge of the agency during those times when the administrator is absent; and (h) Demonstrating to the Health Division upon request that the agency has sufficient resources and the capability to satisfy the requests of each client of the agency related to the provision of the personal care services described in the service plan to the client.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, agency document review, staff interview and employee record review, the agency failed to designate a person to as acting administrator when the administrator is absent.</p> <p>1. Review of the agency's job description for the administrator revealed a required responsibility of the administrator to, "Designate, in writing, a qualified employee to act in their absence."</p>	P 060			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 060	Continued From page 2  2. Review of 10 of 10 employee files revealed a lack of documentation that a written designation of an administrative designee had been assigned.  3. Interview with the administrator on 11/01/10 revealed that the agency was assigning Employee #2 and Employee #3 the duties of an administrator's designee without ensuring that they were qualified and without giving them a written designation.  Scope: 3    Severity: 2	P 060			
P 230	Section 16.1(a-i) Personnel File  Sec. 16. 1. A separate personnel file must be kept for each attendant of an agency and must include, without limitation: (a) The name, address and telephone number of the attendant; (b) The date on which the attendant began working for the agency; (c) Documentation that the attendant has had the tests or obtained the certificates required by NAC 441A.375; (d) Evidence that the references supplied by the attendant were checked by the agency; (e) Evidence of compliance with NRS 449.179 by the administrator of the agency or the person licensed to operate the agency with respect to the attendant; (f) Proof that, within 6 months after the attendant began working for the agency, the attendant obtained a certificate in first aid and cardiopulmonary resuscitation issued by the American National Red Cross or an equivalent certificate approved by the Health Division; (g) Proof that the attendant is at least 18 years of age;	P 230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 230	<p>Continued From page 3</p> <p>(h) Proof of possession by the attendant of at least the minimum liability insurance coverage required by state law if the attendant will be providing transportation to a client in a motor vehicle; and</p> <p>(i) Documentation of all training attended by and performance evaluations of the attendant.</p> <p>This STANDARD is not met as evidenced by: Based on personnel record review, the agency did not have the required documentation in the employee files as required by statutes for 6 of 10 employees. (Employee #1, #2, #3, #4, #5 and #9)</p> <p>1. Employee files #2,#3,#4 and #5 lacked documented evidence that the references provided by the employee had been checked.</p> <p>2. Employee #1, #2, #3, #4 and #9 lacked documented evidence of a performance evaluation.</p> <p>Scope: 2      Severity: 2</p>	P 230			
P 480	<p>Section 21.1(5) Written Client Rights Requirements</p> <p>5. The written description of the rights of clients developed pursuant to subsection 4 must include, without limitation, a statement that each client has the right:</p> <p>(a) To receive considerate and respectful care that recognizes the inherent worth and dignity of each client;</p> <p>(b) To participate in the development of the service plan established for the client and to</p>	P 480			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 480	<p>Continued From page 4</p> <p>receive an explanation of the personal care services provided pursuant to the service plan and a copy of the service plan;</p> <p>(c) To receive the telephone number of the Bureau which may be contacted for complaints;</p> <p>(d) To receive notification of any authority of the Health Division to examine the records of the client as related to the regulation and evaluation of the agency by the Health Division;</p> <p>(e) To receive from the agency, within the limits set by the service plan established for the client and within the program criteria, responses to reasonable requests for assistance; and</p> <p>(f) To receive information, upon request, concerning the policies and procedures of the agency, including, without limitation, the policies and procedures of the agency relating to charges, reimbursements and determinations concerning service plans.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the agency failed to provide a complete written description of Client's Rights for 10 of 10 clients. (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10)</p> <p>1. Ten client files were reviewed. All client files lacked documented evidence of a complete description of client rights. The list of Client's Rights lacked documented evidence of the following:</p> <p>(b) To receive an explanation of the personal care services provided pursuant to the service plan and a copy of the service plan;</p> <p>(c) To receive the telephone number of the Bureau which may be contacted for complaints;</p> <p>(d) To receive notification of any authority of the</p>	P 480			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS5401PCA</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL VALLEY HOME HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>535 S DECATUR BLVD LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 480	Continued From page 5  Health Division to examine the records of the client as related to the regulation and evaluation of the agency by the Health Division; (f) To receive information, upon request, concerning the policies and procedures of the agency, including, without limitation, the policies and procedures of the agency relating to charges, reimbursements and determinations concerning service plans.  Scope: 3          Severity: 2	P 480			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.